

FILED JAN 19 1951

State File No. 2887

35

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. 1002		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2-169	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Missouri Baptist Hosp.				d. STREET ADDRESS (If rural, give location) 1925 Belt Ave.			
3. NAME OF DECEASED (Type or Print)		a. (First) Seth		b. (Middle) c.		c. (Last) Powell	
4. DATE OF DEATH		(Month) Jan. 2		(Day) 1951		(Year)	
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 1		8. DATE OF BIRTH April 15 1881		9. AGE (In years last birthday) 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Jefferson City Mo. 0		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Thomas Powell		13b. MOTHER'S MAIDEN NAME Minerva Carlton		14. NAME OF HUSBAND OR WIFE Betty			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Georgia Rinker 1925 Belt Ave.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Brain Abscess ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Abscess Left Temporal Region 4 mos DUE TO (c) Broncho pneumonia Pulmonary II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. edema - Toxic anemia				INTERVAL BETWEEN ONSET AND DEATH 4 mos	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 193X			
22. I hereby certify that I attended the deceased from Nov. 1st, 1950, to Jan. 2nd, 1951, that I last saw the deceased alive on Jan 1st, 1951, and that death occurred at 12:05 am, from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) John R. Kennedy M.D. C.M.A.		23b. ADDRESS 508 no Island Ave.		23c. DATE SIGNED 1/2/51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1		24b. DATE 1/4/51		24c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEMETERY		24d. LOCATION (City, town, or county) (State) Fulton Mo.	
DATE REC'D BY LOCAL REG. JAN 3 1951		REGISTRAR'S SIGNATURE J B Lasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan Funeral Dir. 2849 N. Euclid			

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed *Robert L Brunkman*
Student Embalmer No.

Licensed Embalmer No. *3553*

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.